

RE-EMBODYING MEDICAL EDUCATION FOR HUMANISED CARE: BETWEEN TECHNOLOGY, INCLUSION AND NARRATIVE EXPERIENCE

RIPENSARE LA FORMAZIONE MEDICA COME ESPERIENZA INCARNATA PER UMANIZZARE LA CURA: TRA TECNOLOGIA, INCLUSIONE E NARRAZIONE



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ABSTRACT

The article reflects on the challenges currently shaping the education of health professionals in light of recent technological and social transformations, characterised by the development of artificial intelligence and increasing systemic complexity. Drawing on the theoretical frameworks of *body pedagogics* and *embodied cognition*, it highlights the need to restore centrality to the subjective corporeal dimension in both professional education and the care relationship, in order to promote an experience of care genuinely oriented toward the person.

L'articolo si propone di riflettere sulle sfide che attraversano la formazione dei professionisti della salute alla luce delle più recenti trasformazioni tecnologiche e sociali, caratterizzate dallo sviluppo dell'AI e da una crescente complessità. Il contributo, assumendo come principali cornici di riferimento teorico la pedagogia del corpo e la prospettiva dell'*embodied cognition*, si focalizza sulla necessità di restituire centralità alla dimensione corporea soggettiva tanto nella formazione dei professionisti della salute quanto nella relazione di cura, al fine di garantire un'esperienza autenticamente orientata alla persona.

KEYWORDS

Body pedagogics; narrative medicine; care relationship; inclusivity; technology.

Pedagogia del corpo; medicina narrativa; relazione di cura; inclusività; tecnologia.

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Introduction

In recent years, the education of health professionals has been at the centre of an international debate highlighting the urgency of rethinking educational models and aims in light of the profound transformations shaping contemporary society. The Lancet Commission report (Frenk et al., 2010) emphasised the need to move beyond a model of training primarily oriented towards the transmission of knowledge, promoting instead a paradigm of transformative learning that integrates technical and scientific competence with ethical responsibility, interdisciplinary collaboration, and sensitivity to the complexity of health systems. More recently, the COVID-19 pandemic has accelerated ongoing processes of innovation, profoundly redefining teaching methods and educational priorities (Frenk et al., 2022). Two interrelated issues have emerged as particularly critical. The first concerns the impact of technological innovation, most notably artificial intelligence, which affects not only clinical practice but also the training of future health professionals. The rapid digitalisation of education and the growing use of tools such as online learning, virtual simulation, and telemedicine have deeply transformed learning processes, generating opportunities but also risks associated with an increasingly mediated and, in part, “disembodied” model of professional formation. The second issue concerns inequalities, which have become more visible and, in some cases, exacerbated by technological transformation: limited access to digital resources and health services risks excluding vulnerable individuals and communities, thereby reinforcing pre-existing disparities. In this context, ensuring the right to health in accordance with the principles of equity and social justice also entails preparing professionals who can recognise such inequalities and orient their practice within an inclusive framework – one attentive to cultural, linguistic, and gender diversity and sensitive to the social contexts in which they operate (Brottman et al., 2020). Educating for diversity within health care training therefore means fostering a critical awareness of difference as a resource for care, in line with the perspective outlined by Frenk et al. (2022), which calls for the construction of health systems that are more resilient, equitable, and sustainable.

In response to these challenges, Frenk et al. (2022) propose the education for life model, which provides a comprehensive framework for re-envisioning health-professional education after the COVID-19 pandemic. The model encompasses three interrelated dimensions: learning throughout life, learning to promote and restore healthy lives, and learning to live one’s own life. Within this framework, the

contribution of pedagogical science – particularly in its intersection with narrative medicine (Charon, 2006; Zannini, 2008) – is fundamental to optimising the educational pathways of health professionals. Pedagogical knowledge enhances those dimensions that enrich and complement technical and scientific competence: ethical awareness, relational quality, the ability to listen to patients' illness narratives, and the recognition of subjective corporeality as the locus of lived experience. In this direction, Kelly et al. (2019) and Bleakley (2020) have underlined an increasingly evident tendency in contemporary medicine towards a disembodied practice – one that turns the body from a subject of experience into a mere object of observation and intervention, reducing care to a technical act progressively deprived of its relational depth. In this perspective, medical education risks losing the human dimension of the encounter of care, obscuring the centrality of lived bodies – of both patients and practitioners – as subjects of experience (Benini, 2002). Hence the need to develop a genuine pedagogy capable of re-humanising medicine by recognising the self-formative and relational value of body (Kelly et al., 2019). Building on these premises, this paper offers a theoretical contribution aimed at exploring the role of pedagogy in the education of health professionals, with particular attention to the theme of the body. The work draws primarily on the frameworks of body pedagogics and embodied cognition, in the conviction that processes of knowledge construction are inseparable from lived experience, and that the relationship between health professionals and patient unfolds also, and above all, within an intercorporeal dimension.

1. Technological Innovation and Disembodied Education

University education for health professionals is currently confronted with rapid and profound transformations, largely driven by the evolution of digital technologies and the development of artificial intelligence (AI). These processes are reshaping not only clinical practice but also educational models and training paradigms, prompting critical reflection and the elaboration of new pedagogical directions. With regard to AI, alongside its educational potential – including the personalisation of learning pathways, support for clinical simulation, and the introduction of more objective assessment tools – recent literature also highlights a number of risks and limitations (Shaw, Henning & Webster, 2025; Randhawa & Jackson, 2020; Quinn & Coghlan, 2021). Despite its growing use in medical

education, AI has yet to demonstrate the ability to grasp or replicate those distinctively human competencies that constitute the core of clinical practice – such as managing communicative complexity, engaging in interprofessional collaboration, and exercising judgement in uncertain contexts. According to Shaw et al. (2025), this necessitates an integration rather than a substitution of the human factor, so that the relational and reflective dimensions of training are preserved.

In parallel, Quinn and Coghlan (2021) emphasise the urgency of strengthening AI literacy, which remains insufficient within current health curricula. Their *Embedded AI Ethics Education Framework* proposes embedding dedicated spaces for AI-related ethical reflection within existing bioethics and medical ethics modules – to prevent misuse, underuse or overreliance on AI, and to foster an ethically informed approach that links technical expertise with moral awareness. The authors further emphasise the importance of initially preparing educators, so that they are capable of delivering ethically grounded and pedagogically coherent instruction on the responsible use of AI in health care. In this regard, the World Health Organization (WHO, 2021) report *Ethics and Governance of Artificial Intelligence for Health* serves as a key reference for defining an ethical framework for AI in health care. The document outlines a set of principles that prioritise individual autonomy, the promotion of well-being and safety, transparency and accountability in technology deployment, equity and inclusion in access and application, and system sustainability. These principles – while encouraging a responsible and conscious use of technology – also offer a normative foundation for designing medical and health-professional curricula that integrate the digital with the embodied and relational dimensions of care.

In 2024, the World Health Organization expanded these guidelines with a new document on generative and multimodal large models (LMMs) for health (WHO, 2024), updating the 2021 reflections in light of recent advances in generative AI. This update strengthens the focus on algorithmic transparency, bias mitigation and multidisciplinary collaboration – involving experts in ethics, computer science, and education – as essential preconditions for equitable and safe AI deployment in health care. Beyond AI, the broader evolution of digital technologies has profoundly affected clinical learning environments, transforming how future health professionals are educated. In particular, Simulation-Based Medical Education (SBME) and telemedicine now stand as emblematic domains of this transformation,

where technological innovation, curriculum redesign, and redefinition of pedagogical relationships converge. Medical simulation is widely recognised as an effective methodology for acquiring clinical competences while ensuring patient safety. As Elendu et al. (2024) show, simulation practices – from high-fidelity mannequins to virtual reality and standardised patients – allow learners to practise both technical and communicative skills in controlled environments, reducing the risk of error and fostering reflective learning through debriefing. As highlighted in the review by Elendu et al. (2024), several empirical studies confirm that simulation-based training is consistently more effective than traditional learning methods in enhancing clinical competence. However, despite its pedagogical value, these authors also note limitations: high cost, the challenge of transferring competences from simulated to real contexts, and concerns regarding the realism and transferability of such experiences. Looking ahead, the authors suggest that continuous advancements in artificial intelligence and virtual reality technologies will further enhance the realism, accessibility, and educational impact of simulation training. Similarly, Bouamra et al. (2021) demonstrated, through a simulation-based telemedicine teaching project, that training students in teleconsultation and tele-expertise can enhance their understanding of both the potential and the constraints of this mode of care. The findings report high levels of satisfaction and a positive perception of telemedicine's educational value. However, the authors note that digital mediation may limit certain relational aspects of clinical interaction, making it difficult to reproduce the depth and immediacy of in-person encounters. These experiences show how simulation technologies and telemedicine, despite offering significant learning opportunities, raise crucial questions about the relationship among technology, embodiment and learning. The encounter of care – grounded in sensory perception and bodily reciprocity – risks being progressively replaced by digital interfaces which, though efficient and functional, introduce symbolic and physical distance. Contemporary health-professional education is therefore challenged to integrate technological innovation without relinquishing the embodied dimension of experience, recognising in the body – of the patient, practitioner and student – the privileged site of educational encounter and the construction of knowledge.

2. Equity and Diversity in Health-Professional Education

In contemporary health-professional education, the rapid development of technology intersects with the pressing issues of equity, diversity, and social justice, which have become central to international debates on medical education. While technological innovations raise questions concerning the progressive “disembodiment” of learning processes and the care relationship, further challenges involve the capacity of educational and health care systems to respond to the complex health needs of populations living in increasingly heterogeneous and interconnected societies characterised by growing cultural, ethnic, and linguistic pluralism. In this context, the education of health professionals must promote a model of competence that integrates technical and scientific knowledge with ethical and relational skills, acknowledging the multiplicity of bodies, identities, and lived experiences that shape the care relationships.

As Verdonk and Janczukowicz (2018) emphasise in their editorial dedicated to diversity in medical education, social justice and active reflection on diversity are now an inescapable requirement: “Social justice, and thus, actively thinking about dealing with diversity, needs us now more than ever” (p. 4). The authors invite educators to rethink medical training not merely as the acquisition of competence but as an epistemic and dialogical space for reflecting on the relationships among identity, health, illness, and care: “Fixing the knowledge, both from a biomedical and constructivist perspective, may be promising not only to improve future doctors’ competences, but also because it creates spaces for intentionally discussing identities and what they mean for health, for health care, and thus, for teaching and learning” (p. 4).

Enhancing inclusivity in medical education, therefore, does not simply mean acting on structures, numbers, or access policies, but engaging at the level of knowledge, epistemologies, and teaching practices that sustain knowledge construction. The goal is not only to increase representation or participation, but to renew the ways in which medical knowledge is produced and transmitted, fostering a culture of care oriented towards equity and professional responsibility. Reflection on diversity in health-professional education inevitably intersects with the theme of the body, both because of the profound connection between corporeality and personal identity and because of the central role that bodies play in the care relationships. Within this framework, two concepts offer fruitful tools for promoting an

authentically inclusive educational approach: body diversity and intersectionality. The concept of *body diversity* is grounded in the recognition and valorisation of the plurality that characterises human bodies, highlighting how each individual – through a unique configuration of genetic, cultural, social, environmental, and biographical factors – embodies a singular corporeal identity that cannot be reduced to presumed universal models of “normality”. When medical training and practice are based on such rigid models, anchored to aesthetic, functional, or performative standards, processes of categorisation and marginalisation arise, devaluing diversity and turning it into a criterion of exclusion. Bodies perceived as “non-conforming” are consequently subject to processes of inferiorisation that derive not from intrinsic characteristics, but from sociocultural representations defining deviation from an ideal of efficiency and desirability. Conversely, *body diversity* embraces the full range of human corporeal expression, as well as the multiple ways in which individuals live, interpret, and represent their bodies in relation to themselves, others, and the social world. In this perspective, *body diversity* can serve as a guiding principle in the design of educational pathways that recognise and value the multiplicity of embodied subjectivities inhabiting clinical practice and social life, thereby fostering a more equitable and inclusive professional culture.

The discourse on *body diversity* can be further enriched through the lens of *intersectionality* (Crenshaw, 1989), which illuminates the complexity of identity by showing how corporeal and social experiences result from the dynamic interplay of multiple, overlapping dimensions. As Ceruti (2018) observes when reflecting on the idea of multiple identity, individuals are not only distinct from one another but also internally diverse, embodying a plurality within themselves. From this perspective, the intersectional paradigm reveals that discrimination emerges as the effect of overlapping and interacting forms of oppression, producing multiple layers of inequality that extend into educational, clinical, and professional contexts. Integrating body diversity and intersectionality in the training of health professionals thus means promoting care relationships that are attentive to difference, vulnerability, and inequality. Educational experiences that include reflection on diversity have developed around different themes, aiming to foster in future professionals a critical awareness of their own positionalities, attitudes, and implicit biases. Some focus on deconstructing stereotypes toward people from different cultural backgrounds; others raise awareness of conditions of poverty,

vulnerability, or stigma; still others, adopting an intersectional orientation, explore the interrelations among wellbeing, identity, and care relationships. Recent initiatives in medical education illustrate how intersectional and diversity-responsive curricula are being implemented worldwide. Among these, an intersectionality-based curriculum evaluation conducted at the Amsterdam UMC (Muntinga et al., 2016), the implementation of *Cultural Safety frameworks* across medical schools in Aotearoa New Zealand (Curtis et al., 2019), and the *Decolonising the Medical Curriculum* project at University College London (Wong, Gishen & Lokugamage, 2021) exemplify efforts to integrate critical reflection, narrative workshops, and collaborative learning activities aimed at recognising and deconstructing stereotypes, and at identifying structural inequities. These initiatives represent concrete examples of diversity-responsive curricula in which clinical competence training is interwoven with reflective and dialogical practice. In this direction, the study by Brown Eichenberg et al. (2023) highlights how body diversity, broadly conceived, constitutes a central issue in processes of care, health professionals–patient communication, and professional identity formation. Through an educational session combining reflexivity and critical analysis of implicit bias, the authors emphasise the need to foster awareness, reduce stigma, and enhance relational and communicative quality. Beyond this specific context examined, their work advances a broader pedagogical perspective that recognises the body as a site of meaning, difference, and potential discrimination. In this sense, the practice of care must be accompanied by the imperative to educate towards self-care – cultivating a positive and respectful relationship with one’s own body and with that of others.

3. Body Pedagogics for a Narrative-Based Medicine

As emerged from the previous sections, any attempt to rethink medical education cannot disregard a renewed consideration of the role and meaning of the body, both in learning processes and in the care relationship. Among the paradigms that, in recent decades, have contributed to redefining medical education and practice from a more humanistic perspective, narrative medicine stands out as one of the most significant reference frameworks. Rita Charon (2006) emphasises the need to give greater prominence to the narrative dimension, proposing a vision of the care relationship grounded in the capacity to interpret and understand stories of illness

as embodied expressions of lived experience. Narrative-based medicine, conceived as a complement to evidence-based medicine, promotes authentic and effective communication between health professional and patient, facilitating both diagnostic understanding and the success of treatments. By focusing attention on the narrative, relational, and ethical dimensions of clinical practice, it aims to restore centrality to the person and to the lived body. This approach, designed to enhance both the patient's and the practitioner's experience, takes shape at the intersection of three dimensions: narrativity, relationality, and corporeality (Charon, 2006). Every story of illness is never purely verbal but is manifested through the body that lives and communicates it (Zedda, 2016). For this reason, health professionals must be able to listen to and interpret the narratives that shape the experience of illness – not only through words but also through the voice of the body. As Charon (2006) writes:

“What is required is the skill of stereophonic listening, the ability to hear the body and the person who inhabits it. What is required is the capacity to recognise the many voices of sickness—in their contradiction, their secrecy, and their exposure of the self” (p. 97).

The complexity of illness stories lies precisely in the interweaving of autobiography and corporeality, between the story the subject tells about themselves and that which the body conveys through its expressive presence. At times, a gap or tension may arise between these two dimensions: the body communicates what language fails to express, revealing the tacit layers of experience. For this reason, alongside narrative and communicative competences, medical education should include practices aimed, on the one hand, at “reawakening the senses” (Bleakley, 2020) and, on the other, at exploring corporeal self-awareness and autobiographical reflection (Charon, 2006). Future health professionals should work on their own bodies – as lived bodies – and on the embodied dimension of the care relationship, developing a form of empathy that enables them to recognise in the other not merely a patient, but an embodied human being (Benini, 2022). It is precisely at this point that a pedagogical perspective emerges, oriented towards developing narrative, reflective, and relational competences within a broader framework of body pedagogics (Kelly et al., 2019). From this perspective, the body pedagogics provides a theoretical and practical model for integrating cognitive learning with experiential and perceptual dimensions (Bleakley, 2020). Kelly et al. (2019) propose body pedagogics as an approach capable of reintegrating sensory and corporeal

experience into health-professional education. The body is not a mere technical instrument but a knowing subject that learns through touch, sight, listening, and shared presence within the clinical space. Restoring centrality to the body in medical education means recognising that professional learning is a multisensory and intercorporeal process in which knowledge arises from experience and contact with reality. Similarly, Bleakley (2020) calls for a “re-education of the senses” to counteract the disembodied tendencies of contemporary pedagogy and to revalue perception, attentiveness, and bodily awareness as essential components of clinical understanding. In this sense, the pedagogy of the body assumes a twofold formative significance: it fosters an empathetic and respectful attitude towards difference, while also encouraging a positive relationship with one’s own corporeality in a perspective of self-care (Cambi, 2010; Bruni, 2008), prevention, and well-being. Education through the body thus becomes a fundamental pedagogical device for forming professionals capable of inhabiting the care relationship with presence, awareness, and responsibility. A medical education modelled on a body pedagogics – particularly one oriented towards inclusion – helps to overcome the technicist reduction of medical training and to restore to medical knowledge its most genuinely human dimension: that of an embodied, dialogical, and transformative understanding.

Conclusions

The transformations currently reshaping the education of health professionals – from the impact of digital technologies and artificial intelligence to the challenges posed by cultural and social diversity – demand a profound reflection on the epistemological and ethical foundations of medical education. The technological revolution and the growing complexity of social and health care contexts require training models capable of combining technical competence with relational depth, preventing clinical practice and learning processes from slipping into forms of disembodiment and abstraction. In this scenario, the quality of both care and education depends on the ability to recognise the plurality of bodies, identities, and stories inhabiting the health care space. Experiences of diversity-responsive medical education show that fostering inclusion does not simply mean widening access, but transforming the epistemologies of learning by incorporating reflective, experiential, and narrative practices that nurture situated and critical knowledge. This also entails recognising the body as a mediator between experience,

knowledge, and the care relationship, and restoring to clinical practice the centrality of the subjective corporeal dimension – an indispensable condition for a form of medicine genuinely oriented toward the person.

From this perspective, the need emerges for a body pedagogics that restores the centrality of corporeality in education and in the care relationship (Kelly et al., 2019). Such an approach pursues a dual aim: to provide patients with more effective, equitable, and inclusive experiences of care, while also promoting the psychosocial well-being of professionals themselves by preventing burnout and fostering awareness of their own needs and emotions. As Kelly et al. (2019) remind us, health-professional education is inherently embodied: learning occurs through the senses, gestures, and shared presence within the clinical space. The body – understood not as a technical object but as a subject of experience and knowledge – becomes the point of convergence between learning, care, and social justice. Educating through the body means preparing professionals who are aware of their own embodiment and that of others, capable of recognising vulnerability as a constitutive dimension of the human and of attending to the sensory languages that traverse the care relationship. As Bleakley (2020) argues, medical education must cultivate not only sensitivity – the empathic and affective capacity to respond to others – but also sensibility, the perceptual and sensory awareness that grounds knowledge in the body. Only through this dual education of the senses – cognitive and emotional at once – can medicine rediscover its embodied and dialogical nature. In this sense, a body pedagogics oriented towards inclusion is not a specialised field but an ethical and methodological necessity – the ground on which to rehumanise care and to recompose the fragile link between knowledge, experience, and life.

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